Eastern District of Missouri Prob 46 Attachment J.4
July 2009 Locally approved form

MONTHLY TREATMENT REPORT					
1. VENDOR NAME & BPA NUMBER:			4. USPO/USPTSO NAME:		
2. CLIENT:			5. FOR PERIOD COVERING:		
3. PHASE: (DAC only)			6. TIME IN PHASE/PROGRAM:		
7. CLIENT CONTACTS (include all services the offender is required to attend, including no shows)					
a. Date	b. Service	c. Length of Contact	d. Co-pay amount paid	e. Comments(for no-shows, indicate	how PO was notified)
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8. COMMENTS REGARDING TREATMENT			PROGRESS	9. CLIENT CO-PAY	
				Total Co-Pay Collected during the month	
				Cumulative Balance Due (if applicable)	
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Date/Signature of Counselor: (INVOICE MAY NOT BE PAID IF COUNSELOR'S SIGNATURE IS ABSENT)					